		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041731

Facility Name: PROVENA ST. ANNE CENTER

Address: 4405 HIGHCREST ROAD (Number) ROCKFORD (City) 61107 (Zip Code)

County: WINNEBAGO

Telephone Number: (815) 299-1999 **Fax #** (815) 299-1560

IDPA ID Number: 371127787010

Date of Initial License for Current Owners: 10/6/86

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501 (C3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Lynda Olinski **Telephone Number:** (708) 478-7916

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Michael R. Gordon
(Title) VP of Finance, CFO

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number PROVENA ST. ANNE CENTER # 0041731 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,920	1
2		Skilled Pediatric (SNF/PED)			2
3	59	Intermediate (ICF)	59	21,594	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	179	TOTALS	179	65,514	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	21,255	1,265	14,418	36,938	8
9	SNF/PED					9
10	ICF		20,448		20,448	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,255	21,713	14,418	57,386	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.59%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A - None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/6/86

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number PROVENA ST. ANNE CENTER # 0041731 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	362,153	41,592	24,060	427,805		427,805		427,805			1
2	Food Purchase		345,109		345,109		345,109	2,753	347,862			2
3	Housekeeping	152,740	35,211		187,951		187,951		187,951			3
4	Laundry	32,325	444	132,061	164,830		164,830		164,830			4
5	Heat and Other Utilities			170,808	170,808		170,808	1,397	172,205			5
6	Maintenance	119,261	8,949	60,012	188,222		188,222	48,046	236,268			6
7	Other (specify):* Pastoral Care/Develop	61,081	518	29,136	90,735		90,735	(31,738)	58,997			7
8	**TOTAL General Services**	727,560	431,823	416,077	1,575,460		1,575,460	20,458	1,595,918			8
	B. Health Care and Programs											
9	Medical Director			18,066	18,066		18,066		18,066			9
10	Nursing and Medical Records	3,230,938	202,419	188,589	3,621,946		3,621,946		3,621,946			10
10a	Therapy			776,402	776,402		776,402		776,402			10a
11	Activities	93,550	638	8,727	102,915		102,915	2,452	105,367			11
12	Social Services	92,440		428	92,868		92,868		92,868			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,416,928	203,057	992,212	4,612,197		4,612,197	2,452	4,614,649			16
	C. General Administration											
17	Administrative	298,854	6,645	827,247	1,132,746		1,132,746	(435,736)	697,010			17
18	Directors Fees											18
19	Professional Services			42,096	42,096		42,096	346,057	388,153			19
20	Dues, Fees, Subscriptions & Promotions			83,132	83,132		83,132	(16,737)	66,395			20
21	Clerical & General Office Expenses		33,942	61,673	95,615		95,615	(7,229)	88,386			21
22	Employee Benefits & Payroll Taxes			984,800	984,800		984,800	126,796	1,111,596			22
23	Inservice Training & Education			7,780	7,780		7,780	9,219	16,999			23
24	Travel and Seminar			9,578	9,578		9,578	8,119	17,697			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			83,646	83,646		83,646	9,073	92,719			26
27	Other (specify):* Bad Debt			150,000	150,000		150,000	(82,735)	67,265			27
28	**TOTAL General Administration**	298,854	40,587	2,249,952	2,589,393		2,589,393	(43,173)	2,546,220			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,443,342	675,467	3,658,241	8,777,050		8,777,050	(20,263)	8,756,787			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number PROVENA ST. ANNE CENTER #0041731 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			313,201	313,201		313,201	116,501	429,702			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							215,825	215,825			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							17,880	17,880			34
35	Rent-Equipment & Vehicles			99,483	99,483		99,483	1,812	101,295			35
36	Other (specify):*											36
37	**TOTAL Ownership**			412,684	412,684		412,684	352,018	764,702			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			588,259	588,259		588,259		588,259			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			98,271	98,271		98,271		98,271			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			686,530	686,530		686,530		686,530			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,443,342	675,467	4,757,455	9,876,264		9,876,264	331,755	10,208,019			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number PROVENA ST. ANNE CENTER # 0041731 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	8,363	30		9
10	Interest and Other Investment Income	(5,011)	32		10
11	Discounts, Allowances, Rebates & Refunds	(19,543)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(150,000)	27		24
25	Fund Raising, Advertising and Promotional	(39,727)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (205,918)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	571,686		34
35	Other- Attach Schedule	(34,013)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 537,673		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 331,755		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

PROVENA ST. ANNE CENTER

ID# 0041731

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Development Salares	$ (26,240)	7	1
2	Development Activities/Fundraising	(1,000)	7	2
3	Development Miscellaneous	(4,498)	7	3
4	Development Benefits	(2,275)	22	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(34,013)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PROVENA ST. ANNE CENTER # 0041731 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	2,753	0	0	0	0	0	0	0	0	0	2,753	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,397	0	0	0	0	0	0	0	0	0	1,397	5
6	Maintenance	0	498	47,548	0	0	0	0	0	0	0	0	48,046	6
7	Other (specify):*	(31,738)	0	0	0	0	0	0	0	0	0	0	(31,738)	7
8	**TOTAL General Services**	(31,738)	4,648	47,548	0	0	0	0	0	0	0	0	20,458	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	2,452	0	0	0	0	0	0	0	0	0	2,452	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	2,452	0	0	0	0	0	0	0	0	0	2,452	16
	C. General Administration													
17	Administrative	0	(393,131)	(42,605)	0	0	0	0	0	0	0	0	(435,736)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	37,414	308,643	0	0	0	0	0	0	0	0	346,057	19
20	Fees, Subscriptions & Promotions	(39,727)	22,990	0	0	0	0	0	0	0	0	0	(16,737)	20
21	Clerical & General Office Expenses	(19,543)	12,314	0	0	0	0	0	0	0	0	0	(7,229)	21
22	Employee Benefits & Payroll Taxes	(2,275)	59,561	69,510	0	0	0	0	0	0	0	0	126,796	22
23	Inservice Training & Education	0	9,219	0	0	0	0	0	0	0	0	0	9,219	23
24	Travel and Seminar	0	8,119	0	0	0	0	0	0	0	0	0	8,119	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	9,073	0	0	0	0	0	0	0	0	0	9,073	26
27	Other (specify):*	(150,000)	0	67,265	0	0	0	0	0	0	0	0	(82,735)	27
28	**TOTAL General Administration**	(211,545)	(234,441)	402,813	0	0	0	0	0	0	0	0	(43,173)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(243,283)	(227,341)	450,361	0	0	0	0	0	0	0	0	(20,263)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PROVENA ST. ANNE CENTER # 0041731 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	8,363	0	108,138	0	0	0	0	0	0	0	0	116,501	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,011)	0	220,836	0	0	0	0	0	0	0	0	215,825	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	17,880	0	0	0	0	0	0	0	0	17,880	34
35	Rent-Equipment & Vehicles	0	0	1,812	0	0	0	0	0	0	0	0	1,812	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	3,352	0	348,666	0	0	0	0	0	0	0	0	352,018	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(239,931)	(227,341)	799,027	0	0	0	0	0	0	0	0	331,755	45

Facility Name & ID Number PROVENA ST. ANNE CENTER # 0041731 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food	$	Provena Senior Services	100.00%	$ 2,753	$ 2,753	1
2	V	5	Utilities		Provena Senior Services	100.00%	1,397	1,397	2
3	V	6	Maintenance - Other		Provena Senior Services	100.00%	498	498	3
4	V	11	Activities-Special Events		Provena Senior Services	100.00%	2,452	2,452	4
5	V	17	Admin - Misc. Other	592,995	Provena Senior Services	100.00%	5,828	(587,167)	5
6	V	17	Administrative Salaries		Provena Senior Services	100.00%	194,036	194,036	6
7	V	19	Professional Services		Provena Senior Services	100.00%	37,414	37,414	7
8	V	20	Dues,Subscriptions		Provena Senior Services	100.00%	22,990	22,990	8
9	V	21	Clerical Supplies		Provena Senior Services	100.00%	12,314	12,314	9
10	V	22	Employee Benefits		Provena Senior Services	100.00%	59,561	59,561	10
11	V	23	Education/Conference		Provena Senior Services	100.00%	9,219	9,219	11
12	V	24	Travel		Provena Senior Services	100.00%	8,119	8,119	12
13	V	26	Insurance		Provena Senior Services	100.00%	9,073	9,073	13
14	Total			$ 592,995			$ 365,654	$ * (227,341)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PROVENA ST. ANNE CENTER # 0041731 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Bad Debt	$	Provena Senior Services	100.00%	$ 67,265	$ 67,265	15
16	V	30	Depreciation		Provena Senior Services	100.00%	3,664	3,664	16
17	V	32	Interest		Provena Senior Services	100.00%	220,836	220,836	17
18	V	34	Rent - Facility		Provena Senior Services	100.00%	17,880	17,880	18
19	V	35	Rent - Equipment		Provena Senior Services	100.00%	1,812	1,812	19
20	V	17	Admin Salaries	138,552	Provena Health Services	100.00%	89,803	(48,749)	20
21	V	22	Employee Benefits		Provena Health Services	100.00%	32,534	32,534	21
22	V	30	Depreciation		Provena Health Services	100.00%	104,474	104,474	22
23	V	19	Admin Consulting,Other		Provena Health Services	100.00%	308,643	308,643	23
24	V	17	Information Systems Salaries	95,700	Provena Health Services	100.00%	18,379	(77,321)	24
25	V	22	Information Systems Benefits		Provena Health Services	100.00%	6,738	6,738	25
26	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	8,999	8,999	26
27	V	17	Admin Salaries		Provena Health Services	100.00%	54,425	54,425	27
28	V	22	Employee Benefits		Provena Health Services	100.00%	19,717	19,717	28
29	V	17	Information Systems Salaries		Provena Health Services	100.00%	29,040	29,040	29
30	V	22	Information Systems Benefits		Provena Health Services	100.00%	10,521	10,521	30
31	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	38,549	38,549	31
32	V	39	Ancillary Services - Other	248,240	Provena Senior Services Pharmacy	100.00%	248,240		32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 482,492			$ 1,281,519	$ * 799,027	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number PROVENA ST. ANNE CENTER # 0041731 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PROVENA ST. ANNE CENTER # 0041731 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Provena Senior Services
Street Address: 19065 Hickory Creek Drive, Ste 310
City / State / Zip Code: Mokena, IL60448
Phone Number: (708)478-7900
Fax Number: (708)478-5387

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Management Fee Income	4,942,944	16	$ 22,950	$	592,995	$ 2,753	1
2	5	Utilities	Management Fee Income	4,942,944	16	11,646		592,995	1,397	2
3	6	Maintenance - Other	Management Fee Income	4,942,944	16	4,154		592,995	498	3
4	11	Activities-Special Events	Management Fee Income	4,942,944	16	20,442		592,995	2,452	4
5	17	Admin - Misc. Other	Management Fee Income	4,942,944	16	48,582		592,995	5,828	5
6	17	Administrative Salaries	Management Fee Income	4,942,944	16	1,617,398	1,617,398	592,995	194,036	6
7	19	Professional Services	Management Fee Income	4,942,944	16	311,867		592,995	37,414	7
8	20	Dues,Subscriptions	Management Fee Income	4,942,944	16	191,638		592,995	22,990	8
9	21	Clerical Supplies	Management Fee Income	4,942,944	16	102,640		592,995	12,314	9
10	22	Employee Benefits	Management Fee Income	4,942,944	16	496,473		592,995	59,561	10
11	23	Education/Conference	Management Fee Income	4,942,944	16	76,847		592,995	9,219	11
12	24	Travel	Management Fee Income	4,942,944	16	67,676		592,995	8,119	12
13	26	Insurance	Management Fee Income	4,942,944	16	75,628		592,995	9,073	13
14	27	Bad Debt	Management Fee Income	4,942,944	16	560,691		592,995	67,265	14
15	30	Depreciation	Management Fee Income	4,942,944	16	30,542		592,995	3,664	15
16	32	Interest	Management Fee Income	4,942,944	16	1,840,794		592,995	220,836	16
17	34	Rent - Facility	Management Fee Income	4,942,944	16	149,043		592,995	17,880	17
18	35	Rent - Equipment	Management Fee Income	4,942,944	16	15,101		592,995	1,812	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,644,112	$ 1,617,398		$ 677,111	25

Facility Name & ID Number PROVENA ST. ANNE CENTER # 0041731 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Provena Health Services
Street Address: 9223 West St. Francis Road
City / State / Zip Code: Frankfort, IL 60423
Phone Number: (815)469-4888
Fax Number: (815)469-4864

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Admin Salaries	Operating Expense	1,101,876		$ 714,188	$ 714,188	138,552	$ 89,803	1
2	22	Employee Benefits	Operating Expense	1,101,876		258,738		138,552	32,534	2
3	30	Depreciation	Operating Expense	1,101,876		830,857		138,552	104,474	3
4	19	Admin Consulting,Other	Operating Expense	1,101,876		2,454,578		138,552	308,643	4
5	17	Information Systems Salaries	Operating Expense	761,172		146,180	146,180	95,700	18,379	5
6	22	Information Systems Benefits	Operating Expense	761,172		53,593		95,700	6,738	6
7	6	Information Systems - Equip Mai	Operating Expense	761,172		71,577		95,700	8,999	7
8	17	Admin Salaries	Direct Cost	1,101,876		432,829	432,829	138,552	54,425	8
9	22	Employee Benefits	Direct Cost	1,101,876		156,806		138,552	19,717	9
10	17	Information Systems Salaries	Direct Cost	761,172		230,974	230,974	95,700	29,040	10
11	22	Information Systems Benefits	Direct Cost	761,172		83,678		95,700	10,521	11
12	6	Information Systems - Equip Mai	Direct Cost	761,172		306,605		95,700	38,549	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,740,603	$ 1,524,171		$ 721,822	25

Facility Name & ID Number PROVENA ST. ANNE CENTER # 0041731 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Provena Senior Services Pharmacy
Street Address: 1475 Harvard Drive
City / State / Zip Code: Kankakee, IL 60901
Phone Number: (815)928-6141
Fax Number: (815)946-3238

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Cost			$	$		$ 248,240	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 248,240	25

Facility Name & ID Number PROVENA ST. ANNE CENTER # 0041731 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	Provena Senior Services										215,825	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 215,825	14
15	TOTALS (line 9+line14)						$	$			$ 215,825	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number PROVENA ST. ANNE CENTER # 0041731 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001		10
2002		11
2003		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PROVENA ST. ANNE CENTER COUNTY WINNEBAGO

FACILITY IDPH LICENSE NUMBER 0041731

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number PROVENA ST. ANNE CENTER # 0041731 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 70,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1985	$ 645,354	1
2					2
3	TOTALS			$ 645,354	3

Facility Name & ID Number PROVENA ST. ANNE CENTER # 0041731 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120			1986	$ 3,516,907	$ 100,483	35	$ 100,483	$	$ 1,937,315	4
5	59			1992	2,722,251	90,742	30	90,742		1,035,222	5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1987	3,173	127	25	127		2,157	9
10	VARIOUS			1990	36,288	1,222	15	1,222		17,774	10
11	VARIOUS			1991	30,799		10			30,799	11
12	VARIOUS			1992	10,277		10			10,277	12
13	VARIOUS			1993	8,128		10			8,128	13
14	VARIOUS			1994	9,019	550	10	550		8,621	14
15	VARIOUS			1995	49,560	2,870	13	2,870		27,311	15
16	VARIOUS			1996	48,475	3,363	10	3,363		34,180	16
17	VARIOUS			1997	62,046	1,463	6	1,463		57,417	17
18	VARIOUS			1998	51,201		5			51,201	18
19	VARIOUS			1999	19,372	1,865	5	1,865		19,102	19
20	VARIOUS			2000	61,109	10,847	5	10,847		49,238	20
21											21
22	DESC: 3 WANDER GUARD SYSTEMS			2001	735	147	5	147		515	22
23	DESC: SOS POSTFORM CTOPS & LAMINATES			2001	1,110	159	7	159		555	23
24	DESC: INSTALL NEW WATER SUPPLY LINES			2001	589	118	5	118		413	24
25	DESC: RECIRCULATING PUMP			2001	1,241	248	5	248		868	25
26	DESC: WATER LINE REPAIRS			2001	1,115	223	5	223		780	26
27	DESC: "B" WING DOOR CONTROL			2001	1,595	319	5	319		1,117	27
28	DESC: THRU WALL UNITS & FILTERS			2001	9,245	1,849	5	1,849		6,472	28
29	DESC: ROOF REPAIRS			2001	1,636	327	5	327		1,145	29
30	DESC: PAINT SOCIAL SERVICE & PASTORAL CARE			2001	325	65	5	65		228	30
31	DESC: ROOF REPAIRS			2001	2,957	591	5	591		2,070	31
32	DESC: PAINT PINK FRAMES			2001	170	34	5	34		119	32
33	DESC: ROOFING REPAIRS			2001	796	159	5	159		557	33
34	DESC: SCANDROLI CONSTRUCTION - FRONT LOBBY			2001	26,011	2,601	10	2,601		9,104	34
35	DESC: FRONT LOBBY & MAIN ENTRANCE - ARCHIT			2001	1,637	164	10	164		573	35
36	DESC: TEMPORARY ENTRANCE - FRONT LOBBY			2001	832	166	5	166		582	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number PROVENA ST. ANNE CENTER # 0041731 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DESC: EVAPORATOR ASSEMBLY FOR WALK-IN COOL	2001	$ 1,783	$ 357	5	$ 357	$	$ 1,248	37
38	DESC: MOTOR,RAIN SHIELD, ETC FOR COOLER/FR	2001	1,223	245	5	245		856	38
39	DESC: ROOFING REPAIRS	2001	458	92	5	92		321	39
40	DESC: PAINT N-WING WALLS	2001	565	113	5	113		396	40
41	DESC: FRONT LOBBY - WANDER GUARD SYSTEM	2001	140		2			140	41
42	DESC: ROOFING REPAIRS	2001	916	183	5	183		641	42
43	DESC: SCANDROLI CONSTRUCTION SERVICES - FR	2001	126,561	6,328	20	6,328		22,148	43
44	DESC: PAINT FOUND DIRECTOR OFFICE	2001	209	42	5	42		146	44
45	DESC: DRAIN/HEATER (WALK-IN FREEZER SYSTEM	2001	691	138	5	138		484	45
46	DESC: MOTOR,CAPACITOR,ETC (WALK-IN COOLER/	2001	2,136	427	5	427		1,495	46
47	DESC: CRANKCASE HEATER, BREAKER, MISC (FRE	2001	878	176	5	176		615	47
48	DESC: BLOWER ASSEMBLY (HVAC #21)	2001	868	174	5	174		608	48
49	DESC: ROOFING REPAIRS	2001	717	143	5	143		502	49
50	DESC: PAINT WALLS (RESIDENT, BATH, REST)	2001	600	120	5	120		420	50
51	DESC: ROOF REPAIRS (SCUPPER)	2001	749	150	5	150		524	51
52	DESC: SIMPLEX COMBINATION LOCK	2001	266	53	5	53		186	52
53	DESC: REPLACE AIR COMPRESSOR-FIRE SPRINKLE	2001	3,524	705	5	705		2,467	53
54	DESC: REACH-IN FREEZER REPAIRS	2001	661	110	3	110		661	54
55	DESC: REPLACED PRESSURE CONTROL (COOLER)	2001	751	150	5	150		525	55
56	DESC: PAINT RESIDENTS WALLS (G62, G63 & G6	2001	600	120	5	120		420	56
57	DESC: NORTH HOT WATER HEATER MIXING VALVE	2001	1,424	285	5	285		997	57
58	DESC: WALK-IN FREEZER REPAIRS	2001	874	175	5	175		612	58
59	DESC: PAINT RESIDENT WALLS, DINING RM AREA	2001	660	132	5	132		462	59
60	DESC: WALK-IN FREEZER CONDENSER #24 REPAIR	2001	556	111	5	111		389	60
61	DESC: HOT WATER PIPING	2001	694	139	5	139		486	61
62	DESC: INSTALL FIRE ALARM - FRONT LOBBY	2001	14,772	2,954	5	2,954		10,340	62
63	DESC: PAINT RESIDENTS WALLS	2001	975	195	5	195		683	63
64	DESC: NORTON POWER TRACK HOLDER/CLOSER UNI	2001	557	111	5	111		390	64
65	DESC: BALLASTS (6) & CIRCUIT BREAKERS (2)	2001	614	123	5	123		430	65
66	DESC: FRONT LOBBY EXPANSION	2001	67,538	6,754	10	6,754		23,638	66
67	DESC: PAINT RESIDENT WALLS	2001	450	90	5	90		315	67
68	DESC: INSTALLATION OF SIGNS - LOBBY AREA	2001	693	139	5	139		485	68
69	DESC: NORTH WALK-IN COOLER REPAIRS	2001	2,460	492	5	492		1,722	69
70	TOTAL (lines 4 thru 69)		$ 6,915,160	$ 242,227		$ 242,227	$	$ 3,389,589	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA ST. ANNE CENTER # 0041731 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,915,160	$ 242,227		$ 242,227	$	$ 3,389,589	1
2									2
3	DESC: REACH-IN FREEZER REPAIRS	2001	934	187	5	187		654	3
4	DESC: WALK-IN FREEZER REPAIRS	2001	846	169	5	169		592	4
5	DESC: TESTING ENGINEERS SERVICES	2001	470	94	5	94		329	5
6	DESC: INSTALL NEW WATER SUPPLY LINES - KIT	2001	1,056	264	4	264		924	6
7	DESC: REPLACED TOLIET & INSTALLATION	2001	652	130	5	130		456	7
8	DESC: PAINT RESIDENTS WALLS & WEST DINING	2001	510	102	5	102		357	8
9	DESC: BASEMENT DOOR HOLDERS (2)	2001	723	145	5	145		506	9
10	DESC: THRU THE WALL AIR CONDITIONERS (5)	2001	4,550	910	5	910		3,185	10
11	DESC: BLOWER WHEELS & BEARINGS (2) CHAPEL	2001	677	135	5	135		474	11
12	DESC: HOT WATER REPAIRS NORTH WING	2001	909	182	5	182		637	12
13	DESC: ELECTRICAL WORK - NEW ENTRY ADDITION	2001	583	117	5	117		408	13
14	DESC: LOBBY IMPROVEMENTS	2001	8,927	893	10	893		3,124	14
15	DESC: LOBBY AREA SERVICES	2001	21,101	2,110	10	2,110		7,385	15
16	DESC: HAVC #1, #2, #18 REPAIRS	2001	2,005	401	5	401		1,404	16
17	DESC: STEAMER REPAIRS	2001	2,062	412	5	412		1,443	17
18	DESC: HVAC #12 & HVAC #20 REPAIRS	2001	1,120	224	5	224		784	18
19	DESC: TRASH RECEPTACLE, SAND TOP URN	2001	247		2			247	19
20	DESC: LANDSCAPE - NEW ENTRANCE	2001	1,271		1			1,271	20
21	DESC: SEAL COATING OF FENCE IN PARK AREA B	2001	585	98	3	98		585	21
22	DESC: INSTALL NW DOOR INTERCOM	2001	1,186	237	5	237		830	22
23	DESC: COMPLETED SIGNED REPAIRS	2001	880	176	5	176		616	23
24	DESC: WEATHERPROOF KEY PAD & PROGRAMMED	2001	230	46	5	46		161	24
25	DESC: LOBBY & MAIN ENTRANCE	2001	9,049	905	10	905		3,167	25
26	DESC: RESET SYSTEM & FIX LEAK IN CAFE	2001	680	136	5	136		476	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,976,412	$ 250,299		$ 250,299	$	$ 3,419,605	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA ST. ANNE CENTER # 0041731 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,976,412	$ 250,299		$ 250,299	$	$ 3,419,605	1
2									2
3	DESC: PAINT WALLS - HANG WALLPAPER	2002	1,936	387	5	387		968	3
4	DESC: CANOPY FOR WEST UNIT	2002	3,760	251	15	251		627	4
5	DESC: WEST UNIT AWNING	2002	3,085	206	15	206		514	5
6	DESC: TAPESTRY FOR LOBBY	2002	850	170	5	170		425	6
7	DESC: REPLACEMENT NORTH WING WATER HEATER	2002			10			117	7
8	DESC: MCQUAY SUITE II	2002			10			419	8
9	DESC: CARPET INSTALLATION AND VINYL BASE I	2002	985	197	5	197		197	9
10	DESC: PATIENT LIFT	2002	1,302	130	10	130		325	10
11	DESC: REPLACEMENT CARPETING FOR CHAPEL	2002	3,633	727	5	727		1,090	11
12									12
13	DESC: RENOVATION OF HALL AND CAFETERIA	2003	8,389	559	15	559		839	13
14	DESC: REPLACEMENT WATER HEATER	2003	4,600	460	10	460		690	14
15	DESC: WATER HEATER	2003	5,030	503	10	503		755	15
16	DESC: WATER HEATER REPAIR	2003	156	31	5	31		47	16
17	DESC: CONDENSING UNIT	2003	7,100	710	10	710		1,065	17
18	DESC: HURD WINDOWS	2003	3,540	354	10	354		531	18
19	DESC: MAINTENANCE FOR GENERATOR	2003	1,145	229	5	229		343	19
20	DESC: DIETARY BLOWER	2003	2,575	258	10	258		386	20
21	DESC: SALVAJOR DISPOSER	2003	2,219	222	10	222		333	21
22	DESC: COMMERCIAL CEILING CLEANING	2003	575	115	5	115		115	22
23									23
24	DESC: FLAT ROOF REPAIR	2004	1,350	68	10	135	68	135	24
25	DESC: STRIP AND REAPPLY NEW WALLPAPER	2004	3,810	381	5	762	381	762	25
26	DESC: WATER VALVES	2004	2,200	73	15	147	73	147	26
27	DESC: ROOF REPAIR	2004	18,000	900	10	1,800	900	1,800	27
28	DESC: SEAL AND STRIPE PARKING LOT	2004	1,970	99	10	197	99	197	28
29	DESC: CATERPILLAR GENERATOR ANNUAL MAINTEN	2004	807	403	1	807	403	807	29
30	DESC: GENERATOR HOSES & BOLTS, EXHAUST COU	2004	1,911	191	5	382	191	382	30
31	DESC: INSTALLATION OF AMPLIFIER & SPEAKER	2004	2,041	102	10	204	102	204	31
32	DESC: REPLACE WATER HEATER IN SOUTH UNIT	2004	6,700	335	10	670	335	670	32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,066,081	$ 258,359		$ 260,911	$ 2,552	$ 3,434,494	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA ST. ANNE CENTER # 0041731 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 378,990	$ 49,031	$ 49,031	$	7	$ 261,658	71
72	Current Year Purchases	124,643	5,811	11,622	5,811	11	11,622	72
73	Fully Depreciated Assets	439,334					439,334	73
74	Home Office Allocation			108,138	108,138			74
75	TOTALS	$ 942,966	$ 54,842	$ 168,790	$ 113,949		$ 712,614	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transport	MINI-VAN	1998	$ 43,500	$	$	$	5	$ 43,500	76
77	Maintenance	F150 FORD W SNOWPLOW	1999	23,172				3	23,172	77
78										78
79										79
80	TOTALS			$ 66,672	$	$	$		$ 66,672	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,721,073	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 313,201	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 429,702	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 116,501	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,213,780	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocation - Home Office				17,880			5
6								6
7	TOTAL				$ 17,880 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [x] NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 101,295 Description: Nursing - $92,175.67, Admin - $7,307.55, Home Office - $1,812
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number PROVENA ST. ANNE CENTER # 0041731 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 3	hrs	$	7,180	$ 374,816	$	7,180	$ 374,816	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		567	29,619		567	29,619	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		7,126	371,967		7,126	371,967	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				588,259		588,259	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	14,874	$ 776,402	$ 588,259	14,874	$ 1,364,661	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number PROVENA ST. ANNE CENTER # 0041731 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 8,885,741	$	1
2	Cash-Patient Deposits	102,693		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	8,420,236		3
4	Supply Inventory (priced at)	588,898		4
5	Short-Term Investments			5
6	Prepaid Insurance	7,152		6
7	Other Prepaid Expenses	124,516		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 18,129,236	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,836,704		12
13	Land	6,851,272		13
14	Buildings, at Historical Cost	74,980,161		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	13,506,539		16
17	Accumulated Depreciation (book methods)	(40,776,212)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Goodwill	140,712		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 62,539,176	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 80,668,412	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,746,542	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,611,167		28
29	Short-Term Notes Payable	31,980		29
30	Accrued Salaries Payable	1,849,317		30
31	Accrued Taxes Payable (excluding real estate taxes)	44,053		31
32	Accrued Real Estate Taxes(Sch.IX-B)	240,643		32
33	Accrued Interest Payable	23,513		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Party	988,855		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,536,070	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,363,410		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	143,623		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,507,033	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,043,103	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 72,625,309	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 80,668,412	$	48

***(See instructions.)**

Facility Name & ID Number PROVENA ST. ANNE CENTER # 0041731 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 31,464,506	1
2	Restatements (describe):		2
3			3
4	**Adj. To Reconcile Consolidated Equity and Consolidated**		4
5	**Net Income to Nursing Facility Amounts**	(458,489)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 31,006,017	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,012,966	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,012,966	17
	B. Transfers (Itemize):		
18	**Transfer Debt to Provena Health**	40,606,326	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 40,606,326	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 72,625,309	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number PROVENA ST. ANNE CENTER # 0041731 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,585,911	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,585,911	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,493,040	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,493,040	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	6,670	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	719,873	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	5,075	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 731,618	23
	D. Non-Operating Revenue		
24	Contributions	54,107	24
25	Interest and Other Investment Income***	5,011	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 59,118	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Rebates	19,543	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 19,543	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,889,230	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,575,460	31
32	Health Care	4,612,197	32
33	General Administration	2,589,393	33
	B. Capital Expense		
34	Ownership	412,684	34
	C. Ancillary Expense		
35	Special Cost Centers	588,259	35
36	Provider Participation Fee	98,271	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,876,264	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,012,966	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,012,966	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number PROVENA ST. ANNE CENTER # 0041731 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,088	2,160	$ 97,879	$ 45.31	1
2	Assistant Director of Nursing	2,104	2,240	69,003	30.80	2
3	Registered Nurses	24,433	25,873	606,920	23.46	3
4	Licensed Practical Nurses	40,462	43,067	860,105	19.97	4
5	Nurse Aides & Orderlies	125,410	134,858	1,496,326	11.10	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,760	7,285	100,705	13.82	8
9	Activity Director	2,064	2,148	29,700	13.83	9
10	Activity Assistants	5,801	6,216	63,850	10.27	10
11	Social Service Workers	6,161	6,603	92,440	14.00	11
12	Dietician	2,064	2,320	48,584	20.94	12
13	Food Service Supervisor	1,889	2,161	30,141	13.95	13
14	Head Cook	8,071	8,778	108,897	12.41	14
15	Cook Helpers/Assistants	23,802	24,651	174,531	7.08	15
16	Dishwashers					16
17	Maintenance Workers	7,943	8,679	119,261	13.74	17
18	Housekeepers	16,432	17,783	152,740	8.59	18
19	Laundry	3,860	4,221	32,325	7.66	19
20	Administrator	2,036	2,240	108,751	48.55	20
21	Assistant Administrator	656	760	14,768	19.43	21
22	Other Administrative	4,043	4,347	64,898	14.93	22
23	Office Manager	1,968	2,174	30,789	14.16	23
24	Clerical	6,610	7,027	79,648	11.33	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Pastoral/Developm	2,716	2,960	61,081	20.64	33
34	TOTAL (lines 1 - 33)	297,373	318,551	$ 4,443,342 *	$ 13.95	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	347	$ 23,302	1,3	35
36	Medical Director	$1500/mth	18,066	9,3	36
37	Medical Records Consultant	27	1,160	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	53	2,841	11,3	44
45	Social Service Consultant	4	428	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	431	$ 45,797		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	146	$ 5,713	10,3	50
51	Licensed Practical Nurses	939	30,938	10,3	51
52	Nurse Aides	5	146	10,3	52
53	TOTAL (lines 50 - 52)	1,089	$ 36,797		53

Facility Name & ID Number PROVENA ST. ANNE CENTER # 0041731 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Judy Larson	Administrator	0	$ 64,251
Janelle Chadwick	Administrator	0	44,500
Administrative Staff	Admissions	0	23,936
Administrative Staff	Human Resource	0	34,127
Administrative Staff	Office Manager	0	30,789
Administrative Staff	Reception/Admin Asst	0	81,299
Administrative Staff	Asst Administrator	0	19,953
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 298,854

B. Administrative - Other

Description	Amount
Corporate Service Fee	$ 138,552
Corporate IS Fee	95,700
Mgmt Fee	413,944
Mgmt Fee Interest	179,051
TOTAL (agree to Schedule V, line 17, col. 3)	$ 827,247
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal Expense		$ 80
Clinical Consulting Expense		15,925
Collection Expense		3,768
Employee Opinoin Survey		2,215
Shredding		651
Transportation		13,998
Gift Shop		4,800
Maintenance		659
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 42,096

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 77,108
Unemployment Compensation Insurance	29,158
FICA Taxes	314,542
Employee Health Insurance	402,882
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	17,413
Pension	128,303
Employee Recognition	394
Executive Benefits	6,678
Employment Screenings	8,323
Home Office Allocation	126,796
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,111,596

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 127)	
Dues & Subscriptions	16,188
Advertising & Public Relations	66,944
Home Office Allocation	22,990
Less: Public Relations Expense	( )
Non-allowable advertising	(39,727)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 66,395

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	9,578
Home Office Allocation	8,119
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,697

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PROVENA ST. ANNE CENTER # 0041731 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number PROVENA ST. ANNE CENTER **#** 0041731 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **7783 - Life Services Network**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **Yes** If YES, what is the capacity? **179**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **43,270** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **98,271**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **No** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **not issued yet**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.